STATE OF MAINE

DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION

BUREAU OF INSURANCE

IN RE: REVIEW OF AGGREGATE MEASURABLE COST SAVINGS DETERMINED BY DIRIGO HEALTH FOR THE THIRD ASSESSMENT YEAR	)))))
Docket No. INS-07-900	)

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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL AND FINANCIAL REGULATION
BUREAU OF INSURANCE

RE: REVIEW OF THE DIRIGO	
HEALTH BOARD'S	**)**
DETERMINATION OF	**)**
AGGREGATE MEASURABLE	**)**
COST SAVINGS FOR THE THIRD	**)**
ASSESSMENT YEAR (2008)	**)**
	)

BRIEF OF THE MAINE ASSOCIATION OF HEALTH PLANS

I. INTRODUCTION

In a written decision dated August 3, 2007 ("Decision") the Board of Directors ("Board") of the Dirigo Health Agency ("DHA") has approved aggregate measurable cost savings ("AMCS") for the third assessment year ("Year 3") in three categories: Hospital Savings ($70.6 million); Uninsured/Underinsured Savings ($6,343,400); and Health Care Provider Fees ($5.2 million split between savings derived from periodic interim payments ("PIP") to hospitals ($3.7 million) and savings derived from increased MaineCare reimbursement to physicians ($1.5 million)). With a $4 million offset for overlap among the categories, the Board approved a total of $78,143,400 for Year 3 AMCS. Administrative Record ("AR") at 1, 10.[1]

The Maine Association of Health Plans ("MEAHP") supports DHA's goal of expanding insurance coverage and controlling the growth of healthcare costs in Maine, but the mechanism for financing the expansion of coverage through DirigoChoice remains fundamentally flawed. As in Years 1 and 2, MEAHP still has serious concerns that the Board's determination, particularly regarding Hospital Savings, is not credible, logical or reasonable, and that the Savings Offset Payment ("SOP") financing mechanism will never be sustainable unless a reasonable methodology is developed and applied to measure these savings.

It is critical that the Board's determination of AMCS – the precursor to assessing the SOP against payors – be calculated accurately. If AMCS is overstated and cannot be reasonably recovered by payors, then those Mainers covered in fully-insured plans and through self-funded plans will pay an undue burden, which will cause even more people to lose insurance coverage. AR 6798-99 (Roberts Prefiled Testimony). This is not a sustainable or credible way to fund

[1] For ease of reference and to limit the length of this brief, MEAHP concurs with the points contained in Sections I-III of the Decision, entitled Introduction, Procedural History and Adjudicatory Proceeding. For the record, however, MEAHP reiterates its objection to the fundamentally unfair procedure for the hearing before the Board. The Board's incredibly compressed time frame for the hearing concerning a complex matter with a voluminous record did not allow MEAHP sufficient time to prepare its case adequately, which is a blatant due process violation.

Dirigo, and it promotes the very antithesis of DHA's goal. It is imperative that the Superintendent limit the Board's determination of AMCS to that which can be calculated using a reasonable methodology, which results in a calculation of savings that reasonably can be recovered by payors from health care providers.

MEAHP does not dispute the inclusion of the three categories of savings in the Board's determination of AMCS; the Law Court's recent decision, MEAHP et al v. Superintendent of Insurance et al, 2007 ME 69, ¶59, 923 A.2d 918, 934, allows them to be included. However, the proper method for calculating savings within each of these categories is still very much in dispute, and that is the central issue now before the Superintendent: whether the methodologies adopted by the Board for calculating these three categories of savings, particularly the methodology for calculating Hospital Savings based on hospitals' costs per case-mix-adjusted-discharge ("CMAD"), (as well as the calculations themselves) are reasonably supported by the record.

The Dirigo statute does not prescribe any particular methodology for calculating AMCS. See 24-A M.R.S.A. § 6913(1-10); AR 90-91 (Schramm Hearing Testimony) On cross-examination Schramm agreed that (1) "the statute does not, does it, specify that [the CMAD methodology] is the measure that is to be used in measuring [AMCS]" and (2) "the provision in the statute that defines cost per [CMAD] does not contain the methodology that you have used in years one and two and three within the statute itself." AR 90-91. The Law Court affirmed the Superior Court's Decision approving the Superintendent's determination of Year 1 AMCS without discussing the reasonableness of the methodologies used to calculate savings in Year 1. MEAHP et al v. Superintendent of Insurance et al, 2007 ME 69, ¶59, 923 A.2d 918, 934; AR 121-22 (Schramm Hearing Testimony). On cross-examination Schramm agreed that the Law

Court decision (1) "does not address a specific way of calculating CMAD"; (2) "does not endorse a particular method for calculating costs for CMAD"; and (3) "does not even describe the methodology." AR 121-22. Likewise, the Superior Court found the Superintendent's Year 1 Decision to be supported by substantial evidence, but did not discuss at all the underlying reasonableness of the various savings initiatives in that case. MEAHP et al v. State of Maine, et al., Superior Court Docket No. AP-05-090, 095, 096 (Decided August 4, 2006) at p. 10.[2] In Year 2, the Superintendent approved an amount of AMCS based on a sense of what Board member Beal called "rough justice" rather than on a particular methodology. AR 132 (Beal comment during Hearing). Indeed, the "rough justice" approach was necessary in Year 2 because the Superintendent expressed serious reservations about several aspects of the CMAD methodology for calculating Hospital Savings. AR 2983 (Year 2 Superintendent's Decision).

Although in Year 3 there has been some reduction in the rate of increase in hospital charges due to Dirigo,[3] the evidence is clear that nobody – not payors, not hospitals, not DHA's consultant Schramm Raleigh Health Strategy ("SRHS"), and certainly not the Board – has accurately quantified those savings. AR 6803, 6807-08 (Cheslock Prefiled Testimony); AR 179 (Cheslock, Fishbein and Mcgoldrick Hearing Testimony). Steve Schramm, the principal from SRHS who testified before the Board, claims that the CMAD methodology for calculating Hospital Savings was revised to address the Superintendent's serious concerns in Year 2, but on

[2] In a strongly worded dissent from the Law Court's Decision, Justice Alexander not only highlighted the vagueness in the Dirigo Act as to what constitutes AMCS, but also the constitutional defect in delegating the critical role of interpreting AMCS to the DHA, which relies on this determination each year to fund its own operations and programs. MEAHP therefore preserves its objection that §6913(1)(A) of the Dirigo Health Act as applied by DHA, constitutes an improper delegation of legislative authority and also lacks any reasonable standards or criteria for determining AMCS, which renders it unconstitutionally vague. MEAHP presents this point to protect its right to take additional legal action should it deem it necessary.

[3] As requested by the Board, MEAHP submitted an estimate of savings for each of the categories in question in the Year 3 proceeding, which it provided in a range of three figures, as set forth in an exhibit in the Record at P. 7025. The low range was $11 million, a middle range of $12.4 million and an upper range of $19.8 million dollars.

cross-examination Schramm admitted that they did not make any adjustment (1) for the extent to which savings are reasonably recoverable by the payors, (2) to segregate savings caused by Dirigo from savings caused by numerous other factors (in fact the CMAD methodology still attributes 100% of the difference between actual and projected cost-per-CMAD, every penny, to Dirigo), and (3) for the impact of $58 million in MaineCare cuts. AR 94-99; 378-79.

To compensate for these flaws in the CMAD methodology last year, the Board used a median measure – a form of "rough justice" – to reduce Hospital Savings by approximately $58 million dollars (from DHA's proposal of $72.7 million to $14.5 million). AR 2792 (Year 2 Board Decision). Given all of the flaws with the CMAD methodology in Year 2, the Superintendent approved this "rough justice" approach to Hospital Savings. AR 2974, 2980-83 (Year 2 Superintendent Decision). The CMAD methodology for measuring Hospital Savings for Year 3 is no better than that proposed in Year 2; numerous significant flaws remain, both conceptually and in the methodology's application.

The Board received expert prefiled testimony and heard extensive supplemental testimony from Jack Burke (a principal consulting actuary with Milliman, a world wide leader in providing actuarial consulting services to the health insurance industry, who is an expert on trend analysis as it relates to the health care and health insurance industries), Jack Keane (an independent health care consultant who previously was Director of the Bureau of Hospitals for the Massachusetts Rate Setting Commission and Deputy Directory of the Maryland Health Services Cost Review Commission), and Roland Mercier (an accountant with expertise in Medicare cost reports in hospital finance and reimbursement), regarding all of the flaws in the CMAD methodology. Burke and Keane each provided a reasonable and logical mechanism for determining Hospital Savings in a manner which recognizes the CMAD methodology's flaws.

Burke made one change to Schramm's calculation based on actuarial best practices using the most current and accurate data, and arrived at $8.2 million in Hospital Savings. AR 6768-71 (MEAHP Exhibits 2-2.2 (Burke Prefiled Testimony)), AR 6772-76 (Burke Prefiled Report); AR 6784 (Burke Prefiled Report Attachment 1 – revision to SRHS CMAD calculations); AR 299-346 (Burke Hearing Testimony); AR at 6957 (MEAHP Exhibit 21: Attachment I revised – further revisions to SRHS calculations).

Keane looked outside the box and carried forward the common sense approach from Year 2 based on the overriding fact that the actual difference in Years 2 and 3 between the hospital market basket index ("HMBI") projection from the base period and the Maine actual cost-per-CMAD was the same; he arrived at $14.5 million. AR 6749-67 (MEAHP Exhibit 1-1.1 (Keane Prefiled Testimony)); AR 231-248 (Keane Hearing Testimony); AR 6956 (MEAHP Exhibit 20: table showing Years 2 and 3 CMAD savings). Unlike in Year 2, however, instead of compensating for the CMAD methodology's numerous flaws the Board adopted a five-fold increase in Hospital Savings from Year 2 to Year 3.[4]

The Superintendent should reject the cost-per-CMAD methodology as an unreasonable, fatally flawed approach for measuring Hospital Savings, and should therefore reject the cost-per-CMAD calculation of $70.6 million as determined by the Board. Instead, the Superintendent should adopt Burke's or Keane's reasonable approach and arrive at Hospital Savings in the range of $8 million to $14.5 million. Importantly, if there is to be another AMCS proceeding next

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[4] Board member David obviously struggled with accepting the cost-per-CMAD methodology as a reasonable measure for Hospital Savings. "I'm not totally comfortable with [the CMAD methodology] but it appears to be my only option….", and "I cannot figure out how one integrates…these disparate findings in whether or not there is a way where one would say that the total amount found by Mr. Schramm can be offset by the findings of the other experts." AR 574. David went on: "I don't feel it is my place to adjust any of the methodologies. I think that's for the Superintendent if he or she feels there is a reason to do so." AR 583-84.

year, the Superintendent should direct DHA to develop a new methodology which is reasonable and credible and which addresses the CMAD methodology's numerous flaws.

Regarding Uninsured/Underinsured Savings, the Board accepted Burke's testimony in reducing the savings calculation from DHA's request of $14 million to $6.343 million to account for the fact that payors cannot reasonably recover 100% of such savings. AR 7-8 (Year 3 Board's Decision). In adopting the SRHS report, DHA did not address any of the concerns raised by the MEAHP and Chamber members of the Bad Debt and Charity Care Workgroup as described in detail in the prefiled testimony of Kristine Ossenfort and Katherine Pelletreau. AR at 6866-71 (Ossenfort Prefiled Testimony); AR 6884-98 (Pelletreau Prefiled Testimony). These included: (1) the underlying premise of the bad debt and charity care work group was to replace the entire SOP mechanism and not only one portion thereof; (2) the very broad definition of the "uninsured," which SRHS retained – any person who was uninsured for any time, even one day, in the year prior to enrolling in DirigoChoice or MaineCare; (3) including the underinsured; (4) including MaineCare enrollees through DirigoChoice enrollment and the MaineCare parent expansion, because DHA has no record of how many of these individuals were previously unisnsured, and; (5) including pharmacy claims. AR 6866-71 (Ossenfort Prefiled Testimony); AR 6884-98 (Pelletreau Prefiled Testimony).

As discussed in section IV below, Burke addressed several but not all of these concerns in his testimony and related hearing exhibits. AR 6768-71 (MEAHP exhibit 2-2.2 (Burke Prefiled Testimony)); AR 6777-82 (Burke Prefiled Report); AR 6785-88 (Burke Prefiled Report Attachments IIa and IIb - revisions to SRHS uninsured/underinsured calculations); AR 6789-95 (Burke Prefiled Report Attachments IIIa and IIIb – "Available Savings" calculation notes and "Development of Variable Expense" assumptions to support revisions to SRHS uninsured/underinsured calculations); AR 451-486 (Burke Hearing Testimony); AR at 6958-61 (MEAHP Exhibit 22: Attachments IIa and IIb revised - further revisions to SRHS calculations); AR 6962-65 (MEAHP Exhibit 22: DirigoChoice member Survey conducted by Muskie School of Public Service on prior insurance status of uninsured and underinsured enrollees in DirigoChoice); AR 6966 (MEAHP Exhibit 23: handwritten notes by Burke in support of revised SRHS calculations included in MEAHP Exhibit 22).

As will also be discussed in greater detail in section IV below, the Board's determination of Uninsured/Underinsured Savings based on Burke's testimony and exhibits is reasonable for Year 3 as far as it goes. Milliman had less than two weeks to review the SRHS report and develop its critique, and in that time Milliman could not undertake a comprehensive review of the SRHS methodology and develop all related corrective assumptions. This underscores the due process problems with such a compressed schedule. In any event, the Board's determination at a minimum should warrant a further reduction by the Superintendent to account for the unreasonable definition of "uninsured," which treats a person uninsured for one day prior to enrollment in DirigoChoice or MaineCare on the same basis as a person uninsured for an entire year.

Regarding the PIP Savings, MEAHP supports Mercier's testimony that any such savings already are included in the CMAD methodology's calculation of Hospital Savings, and therefore the Superintendent should approve zero PIP Savings rather than $3.7 million. AR 520-22, 525 (Mercier Hearing Testimony); AR 5763-64 (Mercier Prefiled Testimony). Also, the Board's determination of Hospital Savings using the CMAD methodology should be reduced by $3 million to avoid double-counting last year's PIP Savings. AR 5764 (Mercier Prefiled Testimony).

Regarding savings produced by increased MaineCare reimbursement to physicians, the Board again accepted Burke's critique, particularly his assumption that only between one-half to one-quarter of any such savings could reasonably be recovered by payors, in reducing DHA's $4.1 million request to $1.5 million. AR 6768-71 (MEAHP exhibit 2-2.2 (Burke Prefiled Testimony)); AR at 6772, 6782-83 (Burke Prefiled Report); AR 525-529 (Burke Hearing Testimony). MEAHP contends that this reduced savings calculation is reasonably supported for Year 3 (with the caveat that Milliman only had two weeks to develop its critique and may have additional comments and suggested revisions to this methodology should there be another AMCS proceeding next year).

Finally, if any of the Hospital Savings measured using the CMAD methodology are allowed to stand as reasonably supported, that figure should be reduced by the $4 million overlap with Uninsured/Underinsured Savings, as determined by the Board.

II. STANDARD OF REVIEW

As noted in the Decision, the Board has the burden of proving that its determination of AMCS is reasonable. AR 3. The Superintendent must decide if the AMCS is reasonably supported by the evidence in the Record. 24-A M.R.S.A. §6913(1)(C). The Superintendent has the authority to "issue an order approving, in whole or in part, or disapproving the filing." Id.

III. HOSPITAL SAVINGS

The Board found $70.6 million in AMCS for Year 3 in the category of Hospital Savings. This is by far the largest category of savings approved by the Board for Year 3, and is dramatically more than the Superintendent approved for Hospital Savings in either Year 1 ($33.7 million) or Year 2 ($14.5 million). In comparison to Years 1 and 2, the Board's determination of Hospital Savings for Year 3 is totally unreasonable on its face because the record contains no reasonable basis for a five-fold increase in Hospital Savings from Year 2 to Year 3. AR 233-39 (Keane Hearing Testimony), AR 6749 (Keane Prefiled Testimony); AR 314 (Burke Hearing Testimony) AR 6769 (Burke Prefiled Testimony); AR 6775-76 (Burke Prefiled Report).

The Board arrived at $70 million in Hospital Savings for Year 3 by adopting a methodology based on hospital costs per case-mix-adjusted-discharge ("CMAD"). The CMAD methodology works this way: (1) determine what a "virtual" Maine hospital's cost-per-CMAD was for Year 3; (2) determine the "virtual" Maine hospital's actual cost-per-CMAD for a base period of 2000 to 2004; (3) project what that "virtual" Maine hospital's cost-per-CMAD for Year 3 would have been using the Hospital Market Basket Index ("HMBI") for inflation; (4) determine the difference between the "virtual" Maine hospital's actual and projected cost-per-CMAD for Year 3; and (5) count the difference as AMCS in the form of Hospital Savings. AR 4, 26-27, 34, 68 (Schramm Hearing Testimony); AR 303, 361 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report). This CMAD methodology measures something and produces a dollar figure, but it is totally unreasonable as a method for measuring Hospital Savings as a category of AMCS.

Measuring Hospital Savings on a cost-per-CMAD basis is fundamentally flawed conceptually and therefore any savings calculation using this methodology is per se unreasonable. AR 6775 (Burke Prefiled Report). The Board's application of the CMAD methodology also is fundamentally flawed, meaning the Board's determination of $70.6 million in Hospital Savings is unreasonable. AR 6775 (Burke Prefiled Report). Both in his pre-filed testimony and in his live testimony before the Board, Mr. Burke, Milliman's health insurance consulting actuary with special expertise in trend analysis, testified that measuring hospital savings on a cost-per-CMAD basis is fundamentally flawed both conceptually and in its application. AR 6775 (Burke Prefiled Report).

Conceptually, the CMAD methodology is fatally flawed because: (1) it was never intended as a mechanism for measuring AMCS; (2) it does not account for the extent to which savings are available to be recovered by payors; (3) it does not segregate Dirigo-related savings from savings caused by other factors; (4) it uses a dubious and arbitrary baseline period from which to project future trend; (5) it calculates hospitals' costs without regard for $58 million in MaineCare cuts to hospitals; (6) it is highly susceptible to a hospital's increasing outpatient discharges which increases volume and artificially inflates the hospital's cost-per-CMAD; and (7) the use of either the mean or median creates such a vast difference between calculations using the same data.

The CMAD methodology is flawed in its application because: (1) the Board used a base period of 2000 to 2004 and "added back" "savings" from 2004 when more current and accurate data from 2005 was available; and (2) the Board increased Year 3's Hospital Savings five-fold over Year 2 even though the actual difference in Years 2 and 3 between the HMBI projection from the base period versus the actual Maine trend was the same.

A. The CMAD methodology is conceptually flawed as a measure of Hospital Savings.

1. CMAD was never intended as a mechanism for measuring AMCS.

In its deliberations, the Board itself acknowledged that the CMAD methodology was not intended to measure AMCS. AR 568 (McAfee and Head Deliberations). Rather, the Board noted, the CMAD methodology was approved by hospitals for meeting voluntary targets. AR 568 (McAfee and Head Deliberations). Schramm confirmed the original purpose of the CMAD methodology in his own testimony – it was developed by the Maine Hospital Association for purposes of complying with the voluntary cost restraint targets in the statute and not for measuring AMCS. AR 92.

Schramm testified that the Dirigo Act does not specify how to calculate Hospital Savings as a category of AMCS. AR 90-91. Schramm agreed on cross-examination that (1) “the statute does not … specify that [the CMAD methodology] is the measure that is to be used in measuring [AMCS]” and (2) “the provision in the statute that defines cost per [CMAD] does not contain the methodology that you have used in years one and two and three within the statute itself.” AR 90-91. The Law Court has ruled that Hospital Savings may be included as a category of AMCS, but the Law Court did not rule on the propriety of any particular methodology for counting Hospital Savings. MEAHP et al v. Superintendent of Insurance et al, 2007 ME 69, ¶59, 923 A.2d 918, 934; AR 121-22 (Schramm Hearing Testimony). Schramm agreed on cross-examination that the Law Court decision (1) “does not address a specific way of calculating CMAD,” (2) “does not endorse a particular method for calculating costs for CMAD,” and (3) “does not even describe the methodology.” AR 121-22. Similarly, the Superintendent approved Hospital Savings for Years 1 and 2 but did not certify that the CMAD methodology was a reasonable way to calculate it. AR 1484-85 (Year 1 Superintendent’s Decision); AR 2980-83 (Year 2 Superintendent’s Decision). What Board member Beal called the “rough justice” approach to Hospital Savings in Year 2 indicates that the Board and the Superintendent were highly suspicious of the CMAD methodology in Year 2. AR 132 (Beal comment during Hearing). In Year 3, the CMAD methodology bears the same fundamental problems that required “rough justice” in Year 2.

2. CMAD is a patently unreasonable measure of AMCS because it does not account for “savings” available to be recovered by payors.

Dr. McAfee acknowledged that the notion of "recoverable savings … has to enter into our deliberations" on the amount of savings to be counted as Hospital Savings. AR 336. Burke, Keane and Mercier offered what Board Chair McAfee called "very compelling testimony" about "varying and different perspectives on the entire use of CMAD, its calculation and its value as savings." AR 567-68. And Anthem's Amy Cheslock testified about the process of negotiating with providers and the extent to which savings are or are not recoverable. AR 157-59 (Cheslock Hearing Testimony); AR 6805-06 (Cheslock Prefiled Testimony). But as Burke, Keane, and Schramm all testified, the CMAD methodology makes no attempt to measure savings that are recoverable by payors. AR 307 (Burke Hearing Testimony); AR 254 (Keane Hearing Testimony); AR 96, 378-79 (Schramm Hearing Testimony). On cross-examination Schramm admitted that "in your calculation for cost per CMAD this year, you did not control or test the extent to which any measured savings of cost per CMAD can be captured by private payors in the form of lower negotiated rates for provider." AR 96. Schramm further admitted that "[w]e don't make an adjustment for recoverable savings." AR 378-79. This is a critical flaw, because the entire "Savings Offset Payment" structure is premised upon savings being offset against reductions in payments made by payors and their subscribers over time.

Virtually all hospitals in Maine are paid by commercial payors on a "discount from charges" basis rather than on the basis of a hospital's costs, yet the CMAD methodology measures only hospitals' <u>cost</u>-per-CMAD. AR 74 (Schramm Hearing Testimony); AR 254 (Keane Hearing Testimony); AR 6805 (Cheslock Prefiled Testimony). A reduction in a hospital's cost-per-CMAD does not translate directly to an identical reduction in that hospital's charges to payors; lower costs represent savings to hospitals whereas lower charges represent savings to payors. AR 253-54 (Keane Hearing Testimony); AR 315, 327 (Burke Hearing Testimony); AR 170 (Fishbein Hearing Testimony).

Mr. Burke testified that the CMAD methodology "will assume that 100% of it can be recovered by the payors immediately, and that's an unreasonable assumption to begin with.." AR 315. He further testified that "[i]f [providers] lower their charges, there are savings to the carrier. If [providers] lower their costs, there are savings to the providers." AR 327. Mr. Keane testified that "it's inconsistent and problematic to on one hand say that payors are responsible for recovering cost decreases even though they pay on the basis of charges…. [T]here is not a direct linkage between costs going down and payments from the private sector going down…. There are many impediments to capturing savings." AR 253-54. Dr. Fishbein testified that "I think there clearly is not a one-to-one connection between hospital costs and hospital charges…. [I]f any change in cost is not being passed along in charges, then the entire health care system is not benefiting…." AR 170.

Mr. Schramm admitted on cross-examination that "the difference between cost and charges [is that] when you're looking at hospital costs, your looking at the cost to the hospital … [while] the charge or some part of the charge is what the insurers or the payors have to pay." AR 73-74. Hospitals may reduce their costs without reducing their charges to payors.[5] AR 254 (Keane Hearing Testimony); AR 327 (Burke Hearing Testimony); AR 170 (Fishbein Hearing Testimony). The import of this disconnection between hospitals' costs and hospitals' charges to

[5] Keane advocated for a charge base methodology in his testimony. "[T]here are definite advantages to looking at it on a charge basis primarily because the people who are effected by and who are expected to recover savings under Dirigo are private payors and private payors are paying end charges for the most part, they are not paying on the basis of cost. In fact, the offset that Mr. Schramm and its colleagues made for cost based reimbursement was in direct recognition that the way you pay has a lot to do with whether you recover costs. Medicaid and Medicare for the critical access hospitals pay on the basis of cost. So when costs go down, their payments go down. There is a direct link. But there is not a direct linkage between costs going down and payments from the private sector going down. AR 254.

payors is clear – the CMAD methodology includes "savings" that are not available to be recovered by the payors.[6]

Schramm testified that one of the CMAD methodology's key assumptions is that all of the savings are reasonably recoverable by payors; *i.e.*, that 100% of the $70.6 million dollars are available to be captured by payors in the form of lower charges from hospitals. AR 96-97, 100. This assumption is unreasonable and is not supported by any evidence in the record. It is also contrary to the Board's own acknowledgement that it must consider whether savings are actually recoverable. AR 336 (McAfee Deliberations); AR 8-9 (Year 3 Board Decision).

In the other two categories of savings, Uninsured/Underinsured and Health Care Provider Fees, the Board reduced the amount of "savings" specifically in order to account for the fact that payors could not recover 100% of those savings. In its written decision dated August 3, 2007, the Board wrote the following with respect to Uninsured/Underinsured:

> Mr. Burke also pointed out that it was unreasonable to assume that all savings were available to be recovered [by payors] and that a more accurate methodology <u>would subtract available savings</u> from new dollars to reach a determination of recoverable savings.
>
> The Board shares the concerns raised by the Intervenors and believes that the methodology offered by Mr. Burke is a more reasonable and supportable approach to determine savings from uninsured and under-insured. (emphasis added).

AR 8 (Year 3 Board Decision). And the Board wrote this with respect to Health Care Provider Fees:

> With regard to the physician fees, Intervenors argued it was <u>unreasonable to assume that the increase in fees was available to be recovered as savings</u>….
>
> The Board considered the arguments made by the Intervenors and notes that it shares some of their concerns about the availability of savings from an increase in physician fees…. With regard to the increase in

[6] Mr. Burke testified that a more appropriate and reasonable measure for hospital savings would be to measure direct savings by looking at hospitals that voluntarily reduce their charges to manage to the 3% operating margin in voluntary limit and adding those reductions up to equal savings. AR 327-28.

> physician fees, the Board is not persuaded that it is reasonable to assume the increase is available to pass on the carries and consumers [sic]. (emphasis added).

AR 9 (Year 3 Board Decision).

The Board should have taken the same consistent approach to Hospital Savings. Given this same flaw in Year 2, in fact, the Board adopted "rough justice" by using the median to arrive at $14 million in Hospital Savings rather than DHA's requested $72.7 million. In the Board's deliberations, Board member David obviously struggled with accepting the CMAD methodology as a reasonable measure of Hospital Savings: "I'm not totally comfortable with [the CMAD methodology] but it appears to be my only option….", and "I cannot figure out how one integrates…these disparate findings in whether or not there is a way where one would say that the total amount found by Mr. Schramm can be offset by the findings of the other experts." AR 574. Board member David concluded by essentially asking the Superintendent to intervene: "I don't feel it is my place to adjust any of the methodologies. I think that's for the Superintendent if he or she feels there is a reason to do so." AR 583-84.

By counting as AMCS all reductions in hospitals' costs rather than only those cost reductions reasonably available to be recovered as savings by payors, the CMAD methodology ignores the underlying premise of the SOP, overstates AMCS, and is unreasonable.

3. CMAD is a patently unreasonable measure of AMCS because it does not segregate Dirigo-related savings from savings caused by other factors.

A hospital's cost-per-CMAD is affected by numerous factors, including normally occurring fluctuations in utilization, volume, expenses, and national and regional cost trends. AR 239 (Keane Hearing Testimony); AR 305-09 (Burke Hearing Testimony); AR 6749-6763 (Keane Prefiled Testimony); AR 6768-6770 (Burke Prefiled Testimony); AR 6772-6783 (Burke Prefiled Report). All of these factors can drive a hospital's cost-per-CMAD up or down in a given year. As Schramm, Burke, and Keane all testified, however, the CMAD methodology does not and cannot isolate reductions in hospitals' cost-per-CMAD caused by Dirigo from reductions in hospitals' costs-per-CMAD caused by these numerous other non-Dirigo-related factors. AR 239 (Keane Hearing Testimony); AR 307 Burke Hearing Testimony); AR 6775 (Burke Prefiled Report); AR 95, 379 (Schramm Hearing Testimony). Burke testified that "the greatest problem with the entire analysis is that there's no attempt being made to directly estimate the impact that Dirigo is having on overall system costs." AR 307. Keane testified that "there are all of these other factors, and the methodology proposed here doesn't sort out, in any way, what effects are attributable to Dirigo versus what effects were attributable to these other factors." AR 239.

Burke summed it up in his Prefiled Report:

> The method assumes that the entire difference between the forecasted hospital cost and the "observed cost has been and will continue to be attributable to Dirigo. This is fallacious on its face. Actual measurable costs are due to a variety of factors, many or most of which are not related to Dirigo.

AR 6775.

Schramm admitted on cross-examination that the CMAD methodology does not "contain such a multi-varying [sic] statistical model within it to control for external factors other than Dirigo as they might impact on increases or decreases in cost per CMAD" and does not "address the extent to which identified savings are due to other factors other than Dirigo." AR 95, 379. Instead, Schramm testified that one of the key assumptions of the CMAD methodology is that <u>any</u> reduction in cost-per-CMAD for Year 3, regardless of its provenance, is Dirigo-related and so counts as AMCS. AR 34. Schramm admitted on cross-examination that Dirigo is not the only factor driving volume, utilization rates, acuity patient mix, cost of supplies, and employment labor charges. AR 101-102. This admitted over-counting is patently unreasonable.[7]

Representatives of Aetna, Anthem and Cigna all testified that no provider has been able to isolate Dirigo from other factors that influence a reduction in cost trend in Maine. AR 167-71 (Cheslock, McGoldrick, and Fishbein Hearing Testimony). Dr. Fishbein from Aetna was asked on cross-examination whether his company could isolate the effects of Dirigo on cost increases in Maine by comparing the actual Maine trend figures with national figures projected based on the HMBI inflation factor. He testified that every one of the 15 or 20 factors contained in the HMBI varied by state, "so to assume that the one and only one difference that is occurring in the state of Maine is the presence of Dirigo is absurd." AR 182.

Burke testified that a more appropriate and reasonable measure for Hospital Savings would be to measure direct savings by looking at hospitals that voluntarily reduce their charges to manage to the 3% operating margin in voluntary limit and adding those reductions up to equal savings. AR 327-28. DHA should develop an entirely new methodology to identify what Dirigo actually does and calculate savings based on those assumptions. AR 314 (Burke Hearing Testimony).

4. CMAD is a patently unreasonable measure of AMCS because it uses a dubious and arbitrary baseline period from which to project future trend.

a. <u>The assumption of continual excess trend is unreasonable.</u>

[7] Neither DHA nor SRHS has even attempted to estimate the impact Dirigo is having on the overall healthcare system costs in Maine. As noted by Milliman and other experts in previous years in these proceedings, such a multi-variate statistical model should be used to estimate the true effect of Dirigo on any reductions in medical cost trends in the state. Given the length of time, effort and resources expended by DHA and SRHS over the last three years to developing a methodology to calculate Dirigo-related savings, it is reasonable to expect that they could make a comparable investment to develop an appropriate statistical model. AR 6924-29 (MEAHP Exhibit 13: DHA's contract to pay SRHS $600,000 for consulting work on Year 3, coupled with contracts in years 1 and 2 for $900,000 each year); AR 6930-55 (MEAHP Exhibits 14-19: email showing SRHS commenced working on its calculations of AMCS for Year 3 in February of 2007).

The CMAD methodology compares the "virtual" Maine hospital's actual cost-per-CMAD for Year 3 with a trended projection of what that "virtual" Maine hospital's cost-per-CMAD would have been by applying the HMBI inflation factor to the base period of 2000-2004. AR 26, 62 (Schramm Hearing Testimony). It is a methodology based on trend analysis, and Burke is an expert actuary in healthcare trend analysis from Milliman. AR 299-300 (Burke's Hearing Testimony); AR 6771 (Burke's Prefiled Testimony). The Board found his testimony "compelling" and referred to him as an "acutary's actuary." AR 334 (Beal Deliberations); AR 567(McAfee Deliberations). Burke testified repeatedly and unequivocally that there is no basis in actuarial science for the CMAD methodology's trend projections. AR 302-03, 306-07, 322-24, 333-34, 336 (Burke Hearing Testimony); AR 6769-70 (Burke Prefiled Testimony); AR 6775-76 (Burke Prefiled Report).

The CMAD methodology assumes that if medical costs in Maine were higher than the national average prior to the Dirigo Law being enacted, then absent Dirigo they would continue to trend higher than the national averages. AR 26 (Schramm Hearing Testimony); AR 303, 322-23 (Burke Hearing Testimony); AR 6775 (Burke Prefiled Testimony). According to Burke this assumption is fatally flawed and ignores actuarial science. AR 306. It is a "false assumption that if … Maine exceeded [the] national average for two or three years before Dirigo, it's going to continue." AR 306 (Burke Hearing Testimony). Again, Burke summed this point up in his Prefiled Report:

> Conceptually, expecting Maine's expense per CMAD to increase in excess of national average levels because a few recent years may have done so seems backward. More likely, some "catch up" would be expected, if that had been the recent trend.

AR 6775.

The CMAD methodology ignores the leveling out effect of trend over time and instead rests on the false assumption that if Maine exceeded the national average for two to three years prior to Dirigo, it will continue to do so, and any reduction or reversion to the national average is therefore attributable to Dirigo. AR 303, 306, 324, 333 (Burke Hearing Testimony). "[I]f the state increases in actual costs per discharge, increases at a higher level than the national for a recent period, then I would expect it is more likely for it to … increase at a lower rate for the near future and vice-versa." AR 322-23 (Burke Hearing Testimony). In response to a question by Board Chairman McAfee, Mr. Burke stated that "the notion of excess trend [in Maine versus national trend] should [be] throw[n] out completely." AR 335. Mr. Burke testified "I don't like the notion of assuming excess trend to begin with because I don't think there's any basis in actuarial science for that." AR 336.

Frank McGoldrick, an actuary with CIGNA, also testified that the CMAD methodology's notion of continuous excess trend has no basis in actuarial science. AR 166. "To the extent that you're looking at a small exposure period and to the extent that you're in one of the pieces of the underwriting cycle and you haven't seen the full cycle emerge, that could lend to inaccuracies on your projection piece. Because if you're in a pricing cycle or a competitive cycle, that would have an impact on your future year impact to the extent that you're projecting a piece of that cycle and not the full cycle, that would have an impact on your overall future projection." AR 166 (McGoldrick Hearing Testimony).

Schramm, with no actuarial background, asserted that the CMAD methodology's use of HMBI "brings into the mix the position that Maine health care expenditures have relative to national trends" – and that is it therefore reasonable to presumes 100% of the excess trend is due to Dirigo. AR 32, 102. But Burke testified that using the HMBI trend versus Maine actual costs does not isolate cost growth in Maine due to Dirigo. AR 304-05. Burke also testified that measuring the excess of Maine cost-per-CMAD over the HMBI with a small number of data points and expecting that trend to continue over time is unreasonable. AR 307-08.

b. The base period for the CMAD methodology's projection is unreasonable.

Choosing the proper base period from which to project trend is critical, as Schramm himself testified: "Depending upon the time period that you choose, the projection period would be different. That's why it's very important to pick a reasonable time period." AR 66. The CMAD methodology applies the HMBI to a base period of 2000 to 2004 to project what hospitals' cost-per-CMAD would have been in 2006. Notwithstanding the unreasonableness of continued excess trend discussed above, the Board's use of a base period from 2000 to 2004 is unreasonable in two respects.

First, it is highly selective because, according Mercier's testimony and calculations, 2000 to 2004 is the only base period which produces any Hospital Savings for Year 3 as measured by the CMAD methodology. AR 199-204 (Mercier Hearing Testimony); AR 5,824, 5,343. A base period of 2000 to 2005 produces negative Hospital Savings of roughly $4 million, or negative savings of $11 million if the savings for 2003 (pre-Dirigo, $71.5 million), 2004 (Year 1, $33.7 million), and 2005 (Year 2, $14.5 million) are added back into the calculation. AR 202-03 (Mercier Hearing Testimony); AR 5841 (Chamber Exhibit 8E); and AR 5843 (Chamber Exhibit 8F). The existence of "pre-Dirigo" Hospital Savings in 2003 particularly undermines the credibility of the CMAD methodology. Using a base period of 1999 to 2002 and projecting to 2003 (the year prior to the Dirigo Law being enacted) the CMAD methodology yielded $71 million in "savings." AR 199 (Mercier Hearing Testimony); AR 5838-39 (Chamber Exhibit 8(D)). Hospital Savings prior to enactment of the Dirigo Law clearly are not attributable to

Dirigo, meaning the CMAD methodology for calculating Hospital Savings as a result of Dirigo is fatally flawed.

Second, as Mr. Burke testified, it is "opportunistic" because the use of 2004 rather than 2005 produces significantly more Hospital Savings as measured by the CMAD methodology. AR 307. He further testified that actuarial best practices dictate that any projection of future trend should be based on the most accurate and current data. AR 307, 309, 316, 321, 329 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report). The Superintendent's Year 2 decision also noted that the "further removed the year being measured from the base period the more tenuous the connection and the more questionable the assumption that all subsequent changes are related to Dirigo. Therefore, future amounts calculated from such base periods may not be reasonably supported in future years." AR 2990-91. Even Schramm testified, in accordance with the Superintendent's guidance "that the further removed you get from the base period, the more tenuous the relationship between the savings and [Dirigo]. And so we looked at ways to adjust the base period to make it more closely related to the projection period." AR 31.

But the CMAD methodology omitted the most recent data from 2005; Schramm, who is not an actuary, testified that "honestly, we never considered" including 2005 in the base period. AR 43, 378. Schramm did acknowledge that "you include all of the data within an underwriting cycle as it pertains to premium or a hospital rate cycle as it pertains to costs and charges. ….we would believe it would be inappropriate to remove a particular year out of that cycle because by definition in order to get a full view of the cycle, you have to look at all of the years." AR 56-57. On cross-examination Schramm could not offer any actuarial basis for leaving 2005 out of the base period:

> Q. Is there any actuarial basis for trending the base period through 2004 but not trending it through 2005 that you're aware of?

A. "I'm not sure what you mean by actuarial basis," he said.

AR 100.[8]

As an actuary, Burke referred to Schramm's use of 2004 rather than 2005 in the CMAD methodology's base period as an "opportunistic selection." AR 307. Schramm compounded the highly selective use of the 2000 to 2004 base period by adding back into the base period the $34.7 million dollars in Hospital Savings approved by the Superintendent for 2004 (i.e. Year 1). AR 312-16. Use of the more recent data from 2005 (Year 2 in which the Superintendent approved $14.5 million in Hospital Savings), however, means that only $14.5 million could be added back into the base period.[9] AR 311-16 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report); AR 6957 (MEAHP Exhibit 21: showing updated revisions to SRHS calculations). Burke testified that by using 2004 rather than 2005, the CMAD methodology artificially increased the projected trend of hospitals' cost-per-CMAD for 2006 (i.e. Year 3), which artificially increased the CMAD methodology's calculation of Hospital Savings for Year 3 by approximately $60 million. AR 311-16 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report); AR 6957 (MEAHP Exhibit 21: showing updated revisions to SRHS calculations).

Burke agrees with Keane that only a small decrease in trend in Maine has been noted versus the national trend in Year 3, just as in Year 2. AR 343-44. It is therefore reasonable to use $14.5 million per the Superintendent's Decision in Year 2 to address the non-Dirigo factors

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[8] Schramm testified that there was a two year gap between the base period and the measuring year in the Year 2 Decision, and that somehow the Superintendent had specifically endorsed that two year gap. AR 31, 44. The Superintendent did not endorse a two year gap as a proper way to project trend; he just accepted the projection based on the two year gap that existed for Year 2. AR 2990-91 (Year 2 Superintendent's Decision).

[9] Mr. Burke noted that the $14.5 million dollar figure was deemed to be reasonable by the Superintendent in light of various factors and flaws in the CMAD methodology pointed out by the interveners in the Year 2 Proceeding. AR 329-31. As Burke explained, because 2005 is the more recent year, it is unnecessary to include 2004 and, in fact, would be contrary to actuarial science to include both years. AR 309, 329-30.

which contribute to lower cost-per-CMAD growth, and to adjust for the extent to which savings are reasonably recoverable, including the impact of MaineCare cuts. AR 343-44.

5. CMAD is a patently unreasonable measure of AMCS because it calculates hospitals' costs without regard for $58 million in MaineCare cuts to hospitals.

MaineCare reimbursements to hospitals were cut by $58 million between July 1, 2003 and June 30, 2005. AR 6853-55, 6863-65 (Fishbein Prefiled Testimony). The fact that the cut occurred was not disputed and in fact was confirmed in hearing testimony by Ms. Wyke, Commissioner of Finance and Administration, and Mr. Greene, a Deputy Commissioner of the Maine Department of Health and Human Services. AR 501 (Wyke Hearing Testimony); AR 509-10 (Green Hearing Testimony).[10] This $58 million cut, quite obviously, reduced the amount of money available to hospitals, limiting the extent to which hospitals could reduce charges to payors. AR 500 (Schramm Hearing Testimony). On cross-examination Schramm agreed that "if additional cash received or received earlier reduces cost-shifting from government payors, … decreased reimbursement received from MaineCare increase[s] cost-shifting." AR 500. According to the SRHS report, a guiding principle in their savings calculations for accelerated MaineCare PIP payments and increased MaineCare payments to physicians, as discussed in sections V below, was that as such MaineCare payment enhancements occurred, there would be less pressure on hospitals and physicians to shift cost to payors; this would provide a basis to find "savings." AR 5317 (SRHS Prefiled Report). Under cross-examination Schramm and Greene admitted that the converse was true: "decreased reimbursement received from MaineCare increases cost-shifting." AR 500 (Schramm Hearing Testimony); AR 517 (Greene Hearing Testimony). Therefore, increased cost-shifting by hospitals to payors as a result of the $58

[10] DHA's only retort is the cut was not caused by Dirigo and so should not be considered. AR 501-02 (Wyke Hearing Testimony).

million MaineCare cuts should be reflected in the CMAD methodology. AR 228-29 (Mercier Hearing Testimony).

Mercier testified that when faced with Medicaid cuts (such as the $58 million MaineCare reduction) hospitals must either cut costs or raise charges for inpatient or outpatient services. AR 206. Cutting costs will increase the cost-per-CMAD savings calculation and raising outpatient charges will also increase the cost-per-CMAD savings calculation because outpatient discharge equivalents are based on outpatient charges as a percentage of overall inpatient/outpatient charges at a hospital. AR 206-07 (Mercier Hearing Testimony). The higher the outpatient charges, the more outpatient discharge equivalents and therefore the lower the cost-per-CMAD, which produces "false savings." AR 206 (Mercier Hearing Testimony). Mr. Mercier also testified that the MaineCare cuts described above would result in more cost shifting, which must be accounted for in a calculation of hospital savings. AR 230.

As Mercier testified and as Schramm agreed, the CMAD methodology does not account for the impact of $58 million in MaineCare cuts on the amount of actual Hospital Savings. AR 230 (Mercier Hearing Testimony); AR 97-98, 379 (Schramm Hearing Testimony). On cross-examination Schramm admitted that "[w]e have not factored in any changes in MaineCare downward." AR 97-98. On further cross-examination Schramm again admitted that the Year 3 methodology contained no adjustment for $58 million in MaineCare cuts in Years 1 and 2. AR 379. And by leaving out the $58 million MaineCare cuts, the CMAD methodology is built to overstate the amount of Hospital Savings. It is patently unreasonable.

6. CMAD is a patently unreasonable measure of AMCS because it is highly susceptible to a hospital's increasing outpatient discharges which increases volume and artificially inflates the hospital's cost-per-CMAD.

As noted above, Mercier testified that when faced with a $58 million MaineCare reduction, hospitals can either cut costs or raise charges for inpatient or outpatient services. AR 206. Mercier further testified that by raising outpatient charges hospitals can increase their volume of outpatient discharge equivalents ("OPDEs"), which reduces the hospital's cost-per-CMAD, which produces "false savings." AR 206-07.

The CMAD methodology measure actually combines in-patient and out-patient calculations, and while MEAHP does not assert that any hospitals are currently doing so, it is entirely possible for hospitals to manipulate the calculation of CMAD. AR 240-41 (Keane Hearing Testimony). Hospitals could "manage to the margin" in order to comply with the Dirigo Act's voluntary COM limit by selectively placing the charge increases in the out-patient category, offsetting those out-patient charge increases by less aggressive in-patient charge increases and thereby pass the COM test by artificially improving their performance on the CMAD test. AR 240-41 (Keane Hearing Testimony).

Keane's testimony is crucial regarding the manner in which the use of OPDEs seriously undermines the credibility and reliability of the CMAD methodology:

> "You have an outpatient measure that basically says we define outpatient equivalent discharges by dividing outpatient revenue by the average inpatient revenue per discharge. Well, what that means is that <u>if I want to decrease my CMAD all I do is jack up my outpatient charges.</u> In fact in Maine what you see is that of total hospital charges, it's almost an even split today between inpatient charges and outpatient charges. What that means is in effect is that if I want to increase my outpatient charges 10% then I don't increase my inpatient charges at all then on average I have a 5% charge increase. But <u>that charge increase jacks up the outpatient equivalent discharges and jacks them up to the extent that you would drive the CMAD down sufficiently to wipe out any actual cost increase. So the calculation of CMAD on its face is completely open to the impacts of hospital outpatient charging practices.</u> And if you look at the actual increase in charges from 2000 to 2006, what you see is that inpatient charges have increased 50%, outpatient charges have increased about 125%. Now some of that increase in outpatient charges is

> attributable to increases in outpatient volume. We all know we're getting more ER visits, more ambulatory surgery, etc. Also those services are becoming more intense but some of it has to do with the fact that charges across the country and probably in Maine have been increased disproportionately in the outpatient area. <u>That mere practice has, in and of itself, a depressing effect on the CMAD and consequently an inflating effect on the savings that one calculates if you use that particular methodology</u>."

AR 240-41 (emphasis added). On cross-examination, Keane further testified that the CMAD methodology is patently unreasonable because of the OPDE problem:

> "Well, what I have is data that shows an enormous increase in outpatient charges. And hospitals across the country have dramatically increased their outpatient charges. I have been on any number of conference calls where consultants have been advising CFO's about how they can jack up their outpatient charges, leave their total charges on the inpatient side unchanged, et cetera. I don't know whether Maine CFO's have done it. All I know is that I have seen an enormous increase in outpatient charges. Let's assume it's not going on. Nevertheless, we have a methodology that's patently, on its face, subject to that kind of adjustment."
>
> ....
>
> "Hospitals are probably making a legitimate attempt to control their costs and to control their charge increases but they also have the option of raising their outpatient charges, which hospitals around the country are doing for all kinds of reasons and I expect they're doing some of that in Maine as well. If both of these things operate to control the operating margin and have the effect of potentially artificially reducing the increasing cost per case mix adjusted discharge."

AR 248, 252.

Mercier also testified that raising outpatient charges will also increase the savings calculation because outpatient discharge equivalents are based on outpatient charges as a percentage of overall inpatient/outpatient charges at a hospital. AR 206-07. The higher the outpatient charges, the more outpatient discharge equivalents and therefore the lower the cost-per-CMAD, which produces "false savings." AR 206-07.

While deferring to Keane and Mercier, Burke agreed that the outpatient discharge equivalent measure ("OPDE") depresses hospitals' cost-per-CMAD measure. AR 305.

Schramm conceded that "the ability certainly exists for hospitals to manipulate the outpatient versus inpatient mix." AR 56. Schramm further conceded two other important points on this issue: (1) that increased outpatient utilization could be driving reductions in hospitals' cost-per-CMAD given the way the outpatient volume factor (discharge equivalent) is calculated based on (outpatient) charges; and (2) that there are not enough Dirigo Choice enrollees to drive the increased outpatient volume figures. AR 77-78. According to Schramm's own testimony, the Superintendent can only conclude that something other than Dirigo is driving the OPDE increase, which depresses hospitals' cost-per-CMAD, which artificially increases AMCS.

7. CMAD is a patently unreasonable measure of AMCS because the difference between calculations using the mean and median are so incredible.

Keane testified that the "huge difference" in choosing between median-based and mean-based measures "should be enough to undermine your confidence in the reliability of the savings estimate." AR 243.

> "It's not credible to me that by simply making a choice between the two measures like that … that you can change the estimated savings five-fold. … And the mere fact that the savings fluctuates so enormously based on a basic decision about which measure of central tendency you've got, to me, suggests that the Superintendent and the Board acted reasonably [in Year 2]. They said we have all these problems. When we throw it all into a hat, we think 14.5 is a reasonable number. To go from 14.5 [in Year 2] to 70 million [in Year 3] partly on a reversion to a mean methodology … [is unreasonable]. So I didn't testify it doesn't matter whether you use the mean or the median, I testified that it matters very much. And if it has such a dramatic impact on savings, then you really have to question the reliability of the methodology if it's so subject to a simple choice as to which measure of central tendency you're going to use."

AR 243-44. Keane was unequivocal that any adjustments SRHS made to the CMAD methodology from Year 2 to Year 3 "don't come close enough to justify the difference between 14.5 and 70.6." AR 238.

Burke testified that the debate between median and mean underscores the larger structural problem – that the CMAD methodology does not accurately measure Dirigo-related savings recoverable by payors. AR 306, 315, 335. Whether the median or mean is better depends on the situation; in Year 2 the median was the better method as a way to "throw out" the extraordinary high costs in 2002. AR 335-36 (Burke Hearing Testimony). It will take years according to Mr. Schramm to have the median and mean come together, which is an <u>implicit admission</u> that there is an anomalous number in there so it will take years to soften it with the lower numbers. AR 335-36 (Burke Hearing Testimony).

Mercier also testified that by applying a pre-Dirigo year of savings to the base period, this would further mitigate the effects of the spike in costs in 2002. AR 225. But as Schramm admitted on cross-examination, the CMAD methodology makes no adjustment in Year 3 for the abnormally high costs in 2002. AR 61-62.

B. The CMAD methodology is flawed in application as a measure of Hospital Savings in Year 3.

Even if the Superintendent adopts the fatally flawed CMAD methodology as the means for calculating Hospital Savings, the Superintendent must still review the calculations inside that methodology in order to determine whether the record reasonably supports $70.6 million in Hospital Savings. The CMAD methodology is fatally flawed in its application in at least two ways: (1) as Burke explains, the Board used a base period of 2000-2004 when more current and accurate data from 2005 was available, violating actuarial best practices and the Superintendent's guidance from Year 2; and (2) as Keane explains, the Board increased Year 3's Hospital Savings five-fold over Year 2 even though the actual difference in Years 2 and 3 between the HMBI projection from the base period and the Maine actual cost-per-CMAD was the same.

At the very least, the Superintendent should correct the Board's calculation of Hospital Savings by including 2005 in the base period per Burke or by following the pattern set in Year 2 per Keane.[11] Each is explained in more detail below.

1. The Board used a base period of 2000-2004 when more current and accurate data from 2005 was available, violating actuarial best practices and the Superintendent's guidance from Year 2.

Mr. Burke testified that actuarial best practices dictate that any projection of future trend should be based on the most accurate and current data. AR 307, 309, 316, 321, 329 (Burke Hearing Testimony); AR 6760-70 (Burke Prefiled Testimony) AR 6775-76 (Burke Prefiled Report). The Superintendent's Year 2 decision also noted that the "further removed the year being measured from the base period the more tenuous the connection and the more questionable the assumption that all subsequent changes are related to Dirigo. Therefore, future amounts calculated from such base periods may not be reasonably supported in future years." AR 2990-91. Even Schramm testified, in accordance with the Superintendent's guidance, "that the further removed you get from the base period, the more tenuous the relationship between the savings and [Dirigo]. And so we looked at ways to adjust the base period to make it more closely related to the projection period." AR 31.

But the CMAD methodology omitted the most recent data from 2005; Schramm, who is not an actuary, testified that "honestly, we never considered" including 2005 in the base period. AR 43, 378. Schramm did acknowledge that "you include all of the data within an underwriting

[11] Board member Head stated that she was not sure what to do with Keane's approach. She questioned whether the Board could take the $14.5 million dollars suggested by Keane which the Superintendent found as reasonably supported in Year 2, and she asked what a reasonable alternative methodology would look like? AR 574-75. And very tellingly Board member David stated "I don't feel it is my place to adjust any of these methodologies. I think that is for the Superintendent if he or she feels there is a reason to do so." AR 583-84.

cycle as it pertains to premium or a hospital rate cycle as it pertains to costs and charges. ….[W]e would believe it would be inappropriate to remove a particular year out of that cycle because by definition in order to get a full view of the cycle, you have to look at all of the years." AR 56-57. On cross-examination Schramm could not offer any actuarial basis for leaving 2005 out of the base period:

> Q. Is there any actuarial basis for trending the base period through 2004 but not trending it through 2005 that you're aware of?
> A. I'm not sure what you mean by actuarial basis.

AR 100.

The Board clearly erred by approving the CMAD methodology which used a base period of 2000-2004 rather than 2000-2005 to calculate Hospital Savings for Year 3.[12] AR 309, 329 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report). Using 2004 in the base period allowed SRHS to add back into the base period the $34.7 million dollars in Hospital Savings approved by the Superintendent for 2004 (i.e. Year 1). AR 31 (Schramm Hearing Testimony). This calculation using 2004 in the base period produced $70.6 million in Hospital Savings.[13]

As an actuary, Burke referred to Schramm's improper use of outdated 2004 rather than current 2005 in the CMAD methodology's base period as an "opportunistic selection." AR 307.

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[12] Schramm also testified that there was a two year gap between the base period and the measuring year in the Year 2 Decision, and that somehow the Superintendent had specifically endorsed that two year gap. AR 31. The Superintendent did not endorse a two year gap as a proper way to project trend; he just accepted the projection based on a two year gap.

[13] As Mercier pointed out, 2000-2004 is the only base period that yields "savings" when trended forward to 2006. AR 199-204, 5,824, and 5,343. Schramm's testimony that he did not even consider expanding the base period to 2005, the most recent year prior to the current measuring year, flies in the face of the Superintendent's guidance in the Year 2 decision and raises issues about the credibility and objectivity of the SRHS calculation. These concerns are heightened by internal SRHS notes showing a series of savings figures being reduced by the Board and the Superintendent, apparently anticipating findings that the CMAD calculation is unreasonable in some respects. AR 6984 (Trust Exhibit 8: DHA or SRHS notes bearing Bates No. 1989).

"Other than it produces higher savings, the 2004 figure does not seem to offer any theoretical advantages." AR 6776 (Burke Prefiled Report).

Using the more recent data from 2005 (Year 2) in which the Superintendent approved $14.5 million in Hospital Savings, Burke corrected the error by adding back $14.5 million into the base period rather than the $33.7 million from Year 1.[14] AR 312-15 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report); AR 6957 (MEAHP Exhibit 21: showing updated revisions to SRHS calculations). By using 2004 rather than 2005, the CMAD methodology artificially increased the projected trend of hospitals' cost-per-CMAD for 2006 (i.e. Year 3), which artificially increased the CMAD methodology's calculation of Hospital Savings for Year 3 by approximately $60 million. AR 312-15 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report); AR 6957 (MEAHP Exhibit 21: showing updated revisions to SRHS calculations). Using the CMAD methodology and <u>only making one change</u> – updating it with the more recent 2005 data rather than the 2004 data according to actuarial principles and guidance from the Superintendent – Burke calculated $8.2 million in Hospital Savings for Year 3. AR 312-15 (Burke Hearing Testimony); AR 6775-76 (Burke Prefiled Report); AR 6957 (MEAHP Exhibit 21: showing updated revisions to SRHS calculations).

If the Superintendent is to use the CMAD methodology at all, he should at least use the most recent data available. Only in this way will the CMAD methodology (notwithstanding its many conceptual flaws) be applied reasonably and produce a reasonable number – $8.1 million. While Burke's "real recommendation" is to develop an agreed upon bottom-up methodology that identifies what Dirigo specifically does and calculates savings from that basis, he testified that

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[14]Mr. Burke noted that the $14.5 million dollar figure was deemed to be reasonable by the Superintendent in light of various factors and flaws in the CMAD methodology pointed out by the intervenors in the Year 2 Proceeding. AR 329-31. As Burke explained, because 2005 is the more recent year, it is unnecessary to include 2004 and, in fact, would be contrary to actuarial science to include both years. AR 309, 329-30.

the $8.1 million dollar figure was reasonable based on all of the concerns set forth in the Superintendent's Year 2 Decision and the CMAD methodology's failure to satisfy those concerns. AR 312-15.

2. The Board increased Year 3's Hospital Savings five-fold over Year 2 even though the actual difference in Years 2 and 3 between the HMBI projection from the base period and the Maine actual cost-per-CMAD was the same.

Jack Keane applied what Board member Beal called "a common sense approach" and concluded that Hospital Savings for Year 3 amounted to $14.5 million. AR 259. As the table below graphically demonstrates, the difference between the actual growth rate for cost-per-CMAD in Year 3 versus the HMBI projection from the base period is exactly the same as it was in Year Two: 0.3%. AR 236-37 (Keane Hearing Testimony); AR 6956 (MEAHP Exhibit 20: table comparing Year 1, Year 2, and Year 3). And the Superintendent approved as reasonable the Board's determination of $14.5 million in CMAD savings for Year 2. AR 2980-83 (Year 2 Superintendent's Decision).

YEAR	CMAD ACTUAL	HMBI TREND	DIFFERENCE	CMAD SAVINGS APPROVED
2003 to 2004	3.19%	3.8%	.61%	$33.7m
2004 to 2005	4.0%	4.3%	0.3%	$14.5M
2005 to 2006	4.0%	4.3%	0.3%	$?????

AR 6956 (MEAHP Exhibit 20). Keane testified that fundamentally, the cost-per-CMAD methodology is a volatile measurement (as we have observed with the unusually high cost growth experience in 2002) but the hospitals' performance to contain their costs-per-CMAD has not improved from Year 2 to Year 3 to such a magnitude as to warrant a five-fold increase in savings. AR 233-38 (Keane Hearing Testimony). Nor has the CMAD methodology been adjusted to satisfy the numerous concerns with the methodology iterated in the Superintendent's Year 2 Decision at all, let alone in a manner sufficient to justify a five-fold increase in Hospital

Savings from $14.5 million to $70.6 million. AR 238-39 (Keane Hearing Testimony). The Superintendent's approval in Year 2 of $14.5 million of savings measured against hospitals' costs-per-CMAD is consistent with the experience of hospitals in Year 3, meaning that if any savings are determined to be reasonable at all under in Year 3 measured against hospitals' costs-per-CMAD, it should closely approximate $14.5 million found by the Superintendent to be reasonable under the same circumstances in Year 2. AR 233-39 (Keane Hearing Testimony).

Keane testified in detail about why $70.6 million in Dirigo-related savings for Year 3 is unreasonable:

> "The way I look at it is that what the Dirigo Board tried to do last year and what the Superintendent did in year two was to come up with a reasonable amount of Dirigo-related savings. And what he found was that there were $14.5 million worth of savings. And if you look at the Superintendent's report and much of the discussion that went on last year, what you see is that both the Board and the Superintendent were trying to deal with a mélange of data issues, questions about different methodologies, questions about recoverability of savings, questions about whether cost savings under the CMAD measure should be measured on a cost or a charge basis as well as the issue of to what extent, if there are savings, they were actually produced by Dirigo. So my interpretation, and if you go back to the Superintendent's report, is that he said given all of this and given the fact that Dirigo reported it, the Dirigo board itself, taking all those factors into account, said that there were $14.5 million worth of savings. I think that that was an attempt to come up with a reasonable number given all of these issues. So if I take the 14.5 and I say, okay, given all of those issues, given the deliberations of the Board, given the review by the Superintendent and he concludes that 14.5 million in savings was what probably occurred in year two and I say what has changed? Well, what I see is the market basket index hasn't changed. In other words, the national trend that's partly what we're comparing the Maine experience to. Then I look at the Maine experience. And the actual cost per CMAD went up four percent, 2005 over 2004. That's estimated to go up four percent 2006 over 2005. So the performance was four percent against 4.3 and another estimated four percent against 4.3. <u>So given that experience, if the Superintendent said savings in year two of 14.5, how on earth – how could anybody fathom that the savings in year three would go up fivefold from 14 and half to the originally submitted 74.9 or the 70.6?</u> When I look back at the prior year, year one, when the Superintendent found I think it was 33.7 million, if you look at the actual

> increase in cost, it was better relative to the market basket index. I think it was 3.8 versus 4. – I think it was 4. – 3.8 against 4.1 or 4. some other number. The percentage of the actual cost increase in year one was about 84 percent of the market basket index. The percentage of actual cost increase in year two was about 93 percent of the market basket index. So I look at that and say does it make sense that the [Superintendent] would have approved more savings in year one than in year two? I say yes. The trend was better so that justified higher savings. The trend was better so that justified higher savings. The trend here in actual costs in year two was not as good relative to the market basket index so I would expect smaller savings and that's what the board found and that's what the Superintendent found."

AR233-36 (emphasis added). Keane's common sense approach addresses the criticisms of the CMAD methodology voiced in the Superintendent's Year 2 decision, and so it would be reasonable for the Superintendent to adopt Keane's common sense approach again in Year 3.

IV. UNINSURED/UNDERINSURED

The Board's Year 3 Decision accepted Burke's testimony in reducing the savings calculation from DHA's request of $14 million to $6.343 million to account for the fact that payors cannot reasonably recover 100% of such savings. AR 7-8 (Year 3 Board Decision). DHA did not address any of the concerns raised by the MEAHP and Chamber members of the Bad Debt and Charity Care Workgroup, which have been summarized above in section I (and as described in detail in the prefiled testimony of Krisitine Ossenfort, and Katherine Pelletreau. AR 6866-83 (Ossenfort Prefiled Testimony); AR 6884-6900 (Pelletreau Prefiled Testimony).

Burke addressed several but not all of these concerns in his pre-filed testimony and exhibits and in his hearing testimony and supplemental/updated hearing exhibits. Specifically, Burke modified the SRHS assumptions as to the percentages of medical claims paid by previously uninsured and underinsured enrollees in DirigoChoice, prior to and after enrollment, in keeping with information in the Muskie Survey, which is included in MEAHP Exhibit 22. AR 458-68 (Burke Hearing Testimony); AR 6962-65 (MEAHP Exhibit 22: Burke Report

Attachment IIa). He also adjusted the SRHS calculation by determining what portion of the "new money" was reasonably available to be passed on to payors in the form of lower charges. AR 455. This "available savings" adjustment included netting out the increased variable expense relating to additional services provided to previously uninsured and underinsured individuals who had enrolled in DirigoChoice or MaineCare, and deleting pharmacy claims. AR 6768-71 (MEAHP exhibit 2-2.2 (Burke Prefiled Testimony)); AR 6777-82 (Burke Prefiled Report); AR 6785-88 (Burke Prefiled Report Attachments IIa and IIb - revisions to SRHS uninsured/underinsured calculations); AR at 6789-95 (Burke Prefiled Report Attachments IIIa and IIIb – "Available Savings" calculation notes and "Development of Variable Expense" assumptions to support revisions to SRHS uninsured/underinsured calculations); AR 451-486 (Burke Hearing Testimony); AR 6958-61 (MEAHP Exhibit 22: Attachments IIa and IIb revised - further revisions to SRHS calculations); AR 6966 (MEAHP Exhibit 23: handwritten notes by Burke in support of revised SRHS calculations included in MEAHP Exhibit 22).

Burke did not address the following other concerns expressed by MEAHP and the Chamber, as detailed in exhibit 5 to the prefiled testimony of Katherine Pelletreau: (1) the underlying premise of the Bad Debt and Charity Care Work Group was to replace the entire SOP mechanism and not only one portion thereof; (2) the very broad and unreasonable definition of the "uninsured," which SRHS retained – any person who was uninsured for any time, even one day, in the year prior to enrolling in DirigoChoice or MaineCare; (3) including the underinsured; and (4) including MaineCare enrollees through DirigoChoice enrollment and the MaineCare parent expansion, as DHA has no record of how many of these individuals were previously uninsured. AR 6898-90.

The Board's determination of Uninsured/Underinsured Savings for Year 3 based on Burke's testimony and exhibits is reasonable as far as it goes. Milliman had less than two weeks to review the SRHS report and develop its critique and in that time Milliman could not undertake a comprehensive review of the SRHS methodology and develop all related corrective assumptions. This underscores the due process problems with such a compressed schedule. In any event, the Board's determination at a minimum should warrant a further reduction by the Superintendent to account for the unreasonable definition of "uninsured," which treats a person uninsured for one day prior to enrollment in DirigoChoice or MaineCare on the same basis as a person uninsured for an entire year. AR 406 (Schramm on cross-examination admitting definition of uninsured includes a person if they were uninsured for just one day in the prior year before enrollment).

One additional point must be made which also relates to the increased MaineCare payments to physicians, described below in section V. In both of these initiatives, the Board adopted Burke's testimony to reduce the proposed savings figures to an amount reasonably available to be recovered by payors from providers in form of lower charges over time. The Board made no attempt to make this adjustment on the CMAD methodology measuring Hospital Savings, yet this one category accounts for $70.6 million out of a total of $78,343,400 alleged savings. As has been noted above, the Board made several suggestions to the Superintendent to make such an adjustment. The two-step process for determining AMCS under the Dirigo Act, and the key role of the Superintendent in that process, mandates that such an adjustment be made to correct an otherwise unreasonable determination.

V. <u>PROVIDER FEES</u>

Regarding the PIP Savings, MEAHP supports Mercier's testimony that any such savings already are included in the CMAD methodology's calculation of Hospital Savings, and therefore the Superintendent should approve zero PIP Savings rather than $3.7 million. AR 520-22, 525 (Mercier Hearing Testimony); AR 5763-64 (Mercier Prefiled Testimony). Also, the Board's determination of Hospital Savings using the CMAD methodology should be reduced by $3 million to avoid double-counting last year's PIP Savings. AR 5764 (Mercier Prefiled Testimony).

Regarding savings produced by increased MaineCare reimbursement to physicians, the Board again accepted Burke's critique, particularly his assumption that only between one-half to one-quarter of any such savings could reasonably be recovered by payors, in reducing DHA's request of $4.1 million to $1.5 million. AR 9 (Year 3 Board Decision). MEAHP contends that this reduced savings calculation is reasonably supported for Year 3 (with the caveat that Burke only had two weeks to develop its critique and may have additional comments and suggested revisions to this methodology should there be another AMCS proceeding next year).

VI. DUE PROCESS

As a final matter, MEAHP reiterates its objection to the fundamentally unfair procedure for the hearing before the Board. This is an extremely complicated matter involving a complex series of methodologies requiring manipulation of Medicare cost report data from all 39 of Maine's hospitals, over 3,200 pages of DHA records which were produced only 7 days prior to the DHA hearing, with $92.7 million of alleged AMCS and related savings offset payment obligations hanging in the balance. DHA provided an extraordinarily compressed schedule to conduct discovery, analyze all of SRHS's methodologies and supporting calculations, obtain the above-referenced 3,200 pages of documents in discovery, and prepare for the DHA hearing.

This process has not complied with minimum due process protections and MEAHP notes its objection in order to preserve its rights to take further action as needed in this regard.

VII. CONCLUSION

For all of the reasons set forth above, MEAHP requests that with respect to the following DHA savings intiatives, the Superintendent should:

1. **Hospital Savings** - Reject the cost-per-CMAD methodology as an unreasonable, fatally flawed approach for measuring Hospital Savings, and should therefore reject the cost-per-CMAD calculation of $70.6 million as determined by the Board as not being reasonably supported by the evidence in the record.
2. Direct DHA to develop a new methodology for measuring Hospital Saving**s** in future years which is reasonable and credible and which addresses the CMAD methodology's numerous flaws documented in the record and outlined in this brief.
3. Adopt Burke's or Keane's approach for the year 3 AMCS determination of Hospital Savings in the range of $8 million to $14.5 million as being reasonably supported by the evidence in the record.
4. **Uninsured/Underinsured –** (a) Adopt the Board's determination of $6,343,000 in savings relating to the Uninsured/Underinsured initiative, based on Burke's testimony and exhibits as being reasonably supported by the evidence in the record for Year 3, and (b) reduce that amount to account for the unreasonable definition of "uninsured," which treats a person uninsured for one day prior to enrollment in Dirigo Choice or

MaineCare on the same basis as a person uninsured for an entire year, with the caveat that Milliman only had two weeks to develop its critique and may have additional comments and suggested revisions to this methodology should there be another AMCS proceeding next year.

5. **Periodic Interim Payments ("PIP") to Hospitals –** (a) Approve zero PIP Savings rather than $3.7 million for PIP Savings approved by the DHA Board, because any such savings already are included in the CMAD calculation of Hospital Savings, and (b) reduce the Board's determination of Hospital Savings using the CMAD methodology by $3 million to avoid double-counting last year's PIP Savings.

6. **Increased MaineCare reimbursement to physicians** - Adopt the Board's determination, reducing DHA's $4.1 million request to $1.5 million, as being reasonably supported by the evidence in the record for Year 3 based on Burke's critique and analysis, with the caveat that Milliman only had two weeks to develop its critique and may have additional comments and suggested revisions to this methodology should there be another AMCS proceeding next year.

7. **Overlap** - Reduce any Hospital Savings measured using the CMAD methodology by the $4 million overlap with Uninsured/Underinsured Savings, as determined by the Board.

Dated: August 21, 2007 Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 21, 2007 by 3:00 p.m., a copy of the foregoing **Brief of the Maine Association of Health Plans** was served as follows:

1. The original and two (2) hard copies via U.S. Mail addressed to:

   Eric A. Cioppa, Acting Superintendent
   Attn: Vanessa J. Leon, Docket No. INS-07-900
   Bureau of Insurance
   Maine Department of Professional and Financial Regulation
   #34 State House Station
   Augusta, Maine 04333-0034

2. One (1) hard copy via U.S. Mail addressed to the Superintendent's legal counsel:

   Thomas C. Sturtevant, Jr.
   Assistant Attorney General
   Office of the Attorney General
   #6 State House Station
   Augusta, Maine 04333-0006

3. One (1) hard copy via U.S. Mail addressed to the Superintendent's consultant:

   Compass Health Analytics, Inc.
   Attn: John Kelly
   477 Congress Street, 7th Floor
   Portland, Maine 04101

4. One (1) identical electronic copy addressed to the following pursuant to the August 7, 2007 Order on Intervention and Procedures, as amended August 16, 2007, and the parties' Designation for Service List filed in this matter:

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